(7) Effective January 1, 1994, the case mix payment rate shall be phased in for dates of service through June 30, 1994.

(A) Each provider will receive 50 percent of the rate under the previous system and 50 percent of the rate under the case mix methodology.

(B) Under the case mix methodology, all features of the reimbursement system shall remain with the exception of the health care cost center. The allowance in the health care cost center shall be adjusted by the average case mix index for each facility and based on the resident assessment and classification.

(C) There shall be a "hold harmless" provision for each provider who experiences a rate reduction based on the case mix adjustment for the period from January 1 through June 30, 1994. The rate from the previous payment methodology shall continue if the case mix adjusted rate is less.

(D) Rates shall be adjusted quarterly by the average case mix index for each facility.

(E) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) Effective July 1, 1994, each provider shall receive rates based strictly on the case mix methodology.

(A) There shall be no "hold harmless" provision.

(B) New limits and rates shall be determined on the basis of cost information submitted by the provider and retained for cost auditing.

(C) Rates shall continue to be adjusted quarterly by the case mix index and applied to the health care cost center for each facility.

(D) Detailed computations of the rate for each facility shall be given.

(9) Effective January 1, 1994, resident assessments that cannot be classified shall be assigned the lowest case mix index.

(b) Comparable service rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the medicaid/ medikan program.

(2) The agency shall maintain a registry of private pay rates submitted by providers.

(A) Providers shall notify the agency by certified mail of any private pay rate change and the effective date of that change.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The registry shall become effective on the first day of the third month after the regulation is adopted. The providers shall have the same length of time to notify the agency of the provider's private pay rate or the registry shall reflect the last private pay rate on file.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables.

(A) A differential for a private room can be included in the average private pay rate when medicaid/medikan residents are placed in a private room at no extra charge and the private room is not medically necessary.

(B) Extra charges for ancillaries, routine supplies and other items included in the medicaid/medikan rate or payment outside of the rate, such as oxygen, can be included in the average private pay rate.

(C) If a level of care system is used to determine the average private pay rate, it shall be based on the level of care that best characterizes the overall medicaid/medikan population in the facility. For example, if the overall medicaid/medikan characteristics reflect moderate care, the private pay rate shall be based on the moderate level of care for comparable services.

(4) The average private pay rate shall be based on what the provider reasonably expects to receive from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents.

(5) When providers are notified of the effective date of the medicaid/medikan rate, the following procedures shall be followed.

(A) If the private pay rate indicated on the agency register is lower, then the medicaid/medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry.

(B) Providers who subsequently notify the agency by certified mail of the private pay rate shall have the medicaid/medikan rate adjusted the first day of the month following the date of the certified letter.

(c) Rate for new construction or new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the medicaid/medikan program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed for a rate.

(d) Change of provider.

(1) The payment rate for the first 12 months of operation shall be based on the rate established from the historical cost data of the previous owner or provider. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, it shall also be applied to the new provider's rate.

(2) When the care of the residents may be at risk because the per diem rate of the previous provider is not sufficient for the now provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and

safety standards, and the old provider's rate is less than the average statewide rate, the new provider may submit a request in writing to the agency to file a projected cost report. The provisions of this subparagraph shall not apply when capital improvements, applicable to all providers, are required by new state or federal regulations.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may occur when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit

adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined within 90 days after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(f) Out-of-state providers. The rate for out-of-state providers certified to participate in the Kansas medicaid/medikan program shall be the rate approved by the agency. Out-of-state providers require prior authorization by the agency.

(g) Determination of the rate for nursing facility providers re-entering the medicaid program.

(1) The per diem rate for each provider re-entering the medicaid program shall be determined from:

(A) A projected cost report in those cases where the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

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(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in accordance with this paragraph.

(2) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program. The effective date of this regulation shall be July 1, 1994. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994.)

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Narrative Explanation of Nursing Facility Reimbursement Formula

The narrative explanation of the nursing facility (NF) and NF-Mental Health (NF-MH) reimbursement formula is divided into nine sections. The sections are: Cost Reports, Rate Determination, Retroactive Rate Adjustments, Case Mix Payment System, Reimbursement Limitations, Real and Personal Property Fee, Incentive Factor, Inflation Factors and Rate Effective Date.

**COST REPORTS**

The Nursing Facility Financial and Statistical Report (MS 2004) is the uniform cost report. It is included in Exhibit A-5. It organizes the commonly incurred business expenses of providers into four reimbursable cost centers (administration, plant operating, room and board, and health care). Ownership costs (i.e. mortgage interest, depreciation, lease and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports: All providers not on a projected rate or in the first year of operation are required to file the uniform cost report on a calendar year basis. The requirements for filing the calendar year cost report are found in Exhibit A-5.

When a non arms length change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator
for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12 month calendar year end cost report.

Projected Cost Reports: The filing of projected cost reports are limited to: 1) Newly constructed facilities; 2) Existing facilities new to the program; 3) New providers when the rate of the previous provider places the residents care at risk and the rate is less than the statewide average; or 4) A provider re-entering the program who has not actively participated or billed services for 24 months or more. The requirements are found in Exhibit A-5. The projected cost report is desk reviewed by agency auditors. Rates from the projected cost reports are subject to upper payment limits.

Historical Cost Report Covering Projected Cost Report Period Or The First Year of Operation of a New Provider: The cost report requirements are found in Exhibit A-5.

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**RATE DETERMINATION**

Medicaid rates for Kansas NFs and NFs-MH are determined using a prospective, facility-specific rate setting system. The rate is based on the costs from the latest cost report submitted by the provider. The rate is subject to upper payment limits established by the agency for the limitation period. Computer software has been developed and is used for calculating the facility specific payment rates.

The allowable expenses are divided into four centers in the cost report. The cost centers are Administration, Plant Operating, Room and Board and Health Care. An owner/administrator limitation is applied in determining the allowable cost. This limitation will be explained in detail in another section of this exhibit.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days, subject to an 85% minimum occupancy rule. The greater of the actual resident days for the cost report period or the 85% minimum occupancy based on the number of licensed bed days during the cost report period are used as the total resident days in the rate calculation. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous providers rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule. The rule is applied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

The allowable historic per diem cost is adjusted by the historic and estimated inflation factors. These inflation factors will be explained in greater detail in another section. The inflated allowable historic per diem cost for each cost center is then compared to the cost center per diem limitation.

The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center per diem limitation. Each cost center has a separate limitation. If each cost center limitation is exceeded, the allowable per diem rate is the sum of the four cost center limitations.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and the 24 hour nursing factor. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The 24 hour nursing factor is explained in Exhibit A-18. The add-ons plus the allowable per diem rate equal the total per diem rate.

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## RETROACTIVE RATE ADJUSTMENTS

Retroactive adjustments, as in a retrospective system, are made for the following conditions:

One, a retroactive rate adjustment and direct cash settlement is made when an audit, by the agency, determines that the historic cost report data used to determine the prospective payment rate is in error. The prospective payment rate period is adjusted for the audit corrections.

Two, when a projected cost report is approved to determine an interim rate, a settlement is made after a historic cost report is filed for the same period.

And three, when a new provider, through an arms-length transaction, is reimbursed the rate of the prior provider and files a historic cost report for the first 12 months of operation, a settlement is made based on the difference between the interim rate and the rate from the historic cost report. Please note the change below on January 3, 1994.

All settlements are subject to upper payment limits. A provider is considered to be in "projection status" when they are operating on a projected rate or the rate of the old provider and they are subject to the retroactive rate adjustment.

Effective January 3, 1994:

New providers, on or after January 3, 1994, shall not be considered to be in "projection status" when they assume the rate of a previous provider. There will be no retroactive settlement for the first 12 months of operation. The rate effective date for the first historical cost report will be the first day of the month following the cost report period. Rates initially paid after the effective date of the rate based on the first historical cost report will adjusted to the new rate.

For example, a new provider is licensed and certified on March 1, 1994. They assume the rate from the previous provider. They will file the first historic cost report for the period from March 1, 1994 through February 28, 1995.

There will be no settlement for the period from March 1, 1994 through February 28, 1995. The rate effective date from the first historical cost report will be March 1, 1995. Since there is a delay in submitting the cost report and having a rate established, there will be a retroactive rate adjustment from March 1, 1995, until the rate is given to the fiscal agent for payment.

Only providers filing projected cost reports for interim rates will have a retroactive settlement for the historical cost report covering the projected period.

## CASE MIX PAYMENT SYSTEM

Kansas is one of four States involved in the national Multistate Nursing Facility Case Mix and Quality Demonstration Project. The case mix payment system was partially implemented in Kansas on January 1, 1994. The case mix rate calculation process will follow a process similar to that used under the current system.

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However, under the case mix system, the Health Care cost center upper payment limit will be adjusted by a facility average case mix index (CMI).

The theory behind a case mix payment system is that the characteristics of the residents in a facility rather than the characteristics of the facility should determine the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

Providers are required to submit to the agency the uniform assessment instrument for each resident in the facility. In Kansas, the Minimum Data Set Plus (MDS+) is the uniform instrument. The MDS+ assessments have been maintained in a computer data base.

Each resident's case mix classification will be determined using the Resource Utilization Group, Version III (RUG III) classification system and the most current MDS+ assessment, for the appropriate time period, in the data base for this resident. From this classification, the numeric value or CMI will be determined. Resident assessments that cannot be classified will assigned the lowest CMI for the State.

Once each resident has been classified, a case mix normalization process will be performed annually. The purpose of this process is to set the mean CMI for the State to a value of one (1). In order to accomplish this calculation, the case mix indices for all residents in the State are totalled and divided by the number of residents. The value determined in this calculation will then be divided into each resident's CMI. This will result in the Table showing the normalized numeric value for each RUGs classification. See Exhibit C-2, Page 8. The average CMI for the State will equal one (1).

Now that each resident has been assigned a normalized CMI, the facility average CMI can be calculated. The facility average is determined by adding the CMI for each resident and then dividing by the number of residents.

The next step in the case mix system is to set the limit for the Health Care cost center. This process is slightly different than the method used to set limits for the other cost centers. The base limit will be the upper limit for a case mix of one (1), the statewide average.

Each facility will have its unique Health Care cost center limit. In theory, each facility's cost for resident care are directly related to its CMI. Because of this assumption, one would expect providers caring for residents needing heavier care to incur higher costs. Arraying the facilities' costs and setting limits without adjusting the case mix would result in a less appropriate rate calculation.

Determining the case mix allows the agency to array the facilities' costs and set limits with costs that should be more comparable. The first calculation is to determine what each facility's cost would be at a case mix of one. The technique of adjusting costs for case mix is known as neutralizing the costs.

Neutralizing costs is done by dividing each facility's per diem costs by its normalized facility average CMI. The CMIs used to normalize the Health Care cost will be the most current MDS+ assessment in the database as of the last day of the cost report period. This date is used to match as closely as possible the CMI to the time the costs were incurred. When this set of calculations is complete, the neutralized per diem costs are then arrayed

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and the base upper limit for the Health Care cost center will be calculated using the methodology described for the current system.

Neutralized costs are arrayed weighted by resident days. The median cost is determined. The upper limit is calculated by multiplying the day weighted median by the appropriate add-on percentage.

Each facility's unique upper limit is calculated by multiplying the base limit just established by that facility's normalized CMI. For example, if the normalized case mix index of one (1) results in a base limit of $40, a facility with a CMI of .9 would have a Health Care cost center upper payment limit of $36 ($40 x .9). Likewise, a provider with a CMI of 1.1 would have an upper limit of $44 ($40 x 1.1). The provider would be reimbursed the lower of their inflated Health Care per diem cost or their facility specific, CMI adjusted, upper payment limit.

Rates will be adjusted quarterly for changes in a facility's average CMI. Since the health care allowance is based on the lower of costs or the limit, not all facilities will receive a quarterly rate change. A detailed listing of the computation for the rate change and the CMI listing will be sent to the provider.

Case Mix Implementation January 1, 1994:

The case mix payment rate was phased in for dates of service from January 1 through June 30, 1994. The provider received 50% of the rate under the previous system and 50% of the rate under the case mix methodology. There was a "hold harmless" provision for each provider who experienced a rate reduction based on the case mix adjustment for service days from January 1 through June 30, 1994. The rate from the previous methodology was continued if the case mix adjusted rate was less.

Case Mix System Beginning July 1, 1994:

The case mix payment system was fully implemented on July 1, 1994. The rates were no longer adjusted for the phased-in period. Providers received 100% of the case mix adjusted rate. The "hold harmless" provision was eliminated.

**REIMBURSEMENT LIMITATIONS**

Period:

The upper payment limits are in effect from July 1st through June 30th, unless otherwise specified by a State Plan amendment.

Upper Payment Limitations:

There are two types of upper payment limits. One is the owner/related party/administrator/co-administrator limit. The other is the cost center limits. Each will be described.

Owner/Related Party/Administrator/Co-Administrator Limit:

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Since salaries and other compensation of owners are not subject to the usual market constraints, specific limitations are placed on the amounts reported. First, amounts paid to non working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have the compensation limited by the percent of their total work time to a standard work week. A work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled "Statement of Owners and Related Parties". This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in the Plant Operating, Room and Board or Health Care cost centers in excess of the Kansas Civil Service based salary chart are transferred to the administrative cost center where the excess is subject to the Owner/Related Party/Administrator/Co Administrator per diem compensation limit.

The Schedule C is an array of non owner administrator and co-administrator salaries. The schedule includes the most current historic cost reports in the data base from all active nursing facility providers. The salary information is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than twelve months. The Schedule C for the owner/related party/ administrator/ co-administrator per diem compensation limit is the first schedule run during the annual limitation setting.

The Schedule C is used to set the per diem limitation for all non owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50 bed or larger home is set at the 90th percentile on all salaries reported for non owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15 beds or less facility. A linear relationship is then established between the compensation of the administrator of the 15 bed facility and the compensation of the administrator of a 50 bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limit applies to the non owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the administrative cost center.

Cost Center Limits:

The Schedule B computer run is an array of all per diem costs for each of the four cost centers-Administration, the Plant Operating portion of Property, Room and Board and Health Care. The schedule includes the most recent historic cost report in the data base from all active nursing facility providers. Projected cost reports are excluded from the data base.

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The per diem expenses in each cost center are subject to the 85% minimum occupancy rule for providers reporting costs for the 13th month of operation and after. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/ administrator/co-administrator limitations.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted for historical and estimated inflation, where appropriate. This will bring the costs reported by the providers to a common point in time for comparisons. The historic inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index) for the cost center limits effective July 1st. The historic inflation factor will adjust costs from the midpoint of each providers cost report period to the latest quarterly DRI Index for the Schedule B processing.

The estimated inflation factor will be also be based on the DRI Index. Determination of the estimated inflation factor will begin with the quarter the historic inflation ends. It will be continued to the midpoint of the payment limitation period (December 31st).

Certain costs are exempt from the inflation application when setting the upper payment limits. They include administrators and co-administrator salaries, owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

| | |
|---|---|
| Administration | 120% of the median |
| Plant Operating (Portion of Property) | 130% of the median |
| Room and Board | 130% of the median |
| Health Care | 125% of the median |

The overall Property limit requires additional explanation. The implementation of the real and personal property fee (property fee), effective January 1, 1985, revised the method of determining the property limit. Ownership costs (interest, depreciation, lease or amortization of leasehold improvements) are no longer included in the allowable cost when determining the Medicaid rate. The methodology of the overall property limit needed to be revised after the ownership costs were excluded.

Due to the implementation of the property fee, the calculation methodology of the Total Property cost limit has been revised such that changes in ownership (and resulting increases in ownership costs) after 7/18/84 are not recognized in setting new limits. The change in methodology essentially holds the ownership cost portion of the property limit, effective 10/1/84, constant. The revised methodology only allows for relative changes in the plant operating costs to influence the total Property cost limit.